Public Chapter 157

SENATE BILL NO. 1699

By Fowler, McNally, Atchley, Elsea, Person, Gilbert, Leatherwood, Jordan, Miller, Ramsey, Williams, Carter, Crowe, Koella, Dixon

Substituted for: House Bill No. 1825

By Clabough, McDaniel, Davis, Stamps, Pleasant, Mumpower, Boyer, Hargett, Haley, Beavers, Goins, Newton, Dunn, Sargent, Walker, Patton, Jackson

AN ACT To amend Tennessee Code Annotated, Title 56, Chapter 7, relative to compliance with the Health Insurance Portability and Accountability Act of 1996.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding Sections 2 through 16 of this act as a new, appropriately designated Part.

SECTION 2. This part is known as and may be cited as the "Tennessee Health Insurance Portability, Availability and Renewability Act".

SECTION 3. As used in this part, these terms shall have the following meanings:

(1) "Affiliation Period"

(A) Means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Such period shall begin on the enrollment date.

(C) An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(2) "Beneficiary" has the meaning given such term under Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA).

(3) "Bona Fide Association" means, an association which:

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be established by the commissioner.

(4) "Church Plan" has the meaning given such term under Section 3(33) of ERISA.

(5) "COBRA Continuation Provision" means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of Subtitle B of Title I of ERISA, other than Section 609 of such Act.

(C) Title XXII of the Public Health Service Act.

(6) "Creditable Coverage"

(A) means, with respect to an individual, coverage of the individual under any of the following:

(i) A group health plan.

(ii) Health insurance coverage.

(iii) Part A or Part B of Title XVIII of the Social Security Act.

(iv) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928.

(v) Chapter 55 of Title 10, United States Code.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under Chapter 89 of Title 5, United States Code.

(ix) A public health plan.

(x) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(B) Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits.

(7) "Employee" has the meaning given such term under Section 3(6) of ERISA.

(8) "Employer" has the meaning given such term under Section 3(5) of ERISA, except that such term shall include only employers of two or more employees.

(9) "Enrollment Date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(10) "Excepted Benefits" means benefits under one or more (or any combination thereof) of the following:

(A) Benefits not subject to requirements:

(i) Coverage only for accident, or disability income insurance, or any combination thereof.

(ii) Coverage issued as a supplement to liability insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Workers' compensation or similar insurance.

(v) Automobile medical payment insurance.

(vi) Credit-only insurance.

(vii) Coverage for on-site medical clinics.

(viii) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(B) Benefits not subject to requirements if offered separately:

(i) Limited scope dental or vision benefits.

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(iii) Such other similar, limited benefits as are specified in regulations.

(C) Benefits not subject to the requirements if offered as independent, noncoordinated benefits are coverage only for a specified disease or illness and hospital indemnity or other fixed indemnity insurance.

(D) Benefits not subject to the requirements if offered as a separate insurance policy are medicare supplement insurance, coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(11) "Federal Governmental Plan" means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(12) "Governmental Plan" has the meaning given such term under Section 3(32) of ERISA and any Federal governmental plan.

(13) "Group Health Insurance Coverage" means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(14) "Group Health Plan" means an employee welfare benefit plan (as defined in Section 3(1) of ERISA) to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. A program under which creditable coverage is provided shall be treated as a group health plan for the purposes of applying this part.

(15) "Health Insurance Coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate, or agreement offered by a health insurance issuer.

(16) "Health Insurance Issuer" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to an insurance company, a health maintenance organization and a non-profit hospital and medical service corporation. Such term does not include a group health plan.

(17) "Health Maintenance Organization" means:

(A) a Federally qualified health maintenance organization (as defined under Federal law), or

(B) an organization recognized under State law as a health maintenance organization.

(18) "Health status-related factor" means any of the following factors:

(A) Health status;

(B) Medical condition, including both physical and mental illnesses;

(C) Claims experience;

(D) Receipt of health care;

(E) Medical history;

(F) Genetic information;

(G) Evidence of insurability, including conditions arising out of acts of domestic violence;

(H) Disability.

(19) "Individual Health Insurance Coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(20) "Individual Market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. This includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(21) "Large Employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(22) "Large Group Market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(22) "Late Enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period.

(23) "Medical Care" means amounts paid for:

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(24) "Network Plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(25) "Non-Federal Governmental Plan" means a governmental plan that is not a Federal governmental plan.

(26) "Participant" has the meaning given such term under Section 3(7) of ERISA.

(27) "Placed for Adoption", in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

(28) "Plan Sponsor" has the meaning given such term under Section 3(16)(B) of ERISA.

(29) "Preexisting Condition Exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

(30) "Small Employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employs an average of at least 2 but no more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(31) "Small Group Market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(32) "Waiting Period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

SECTION 4. (a) A group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and,

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

(b) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(c) Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period shall not be taken into account in determining the continuous period under subsection (b).

(d) Method of Crediting Coverage:

(1) Standard Method -- Except as otherwise provided under paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(2) Election of Alternative Method -- A group health plan, or a health insurance issuer offering group health insurance, may elect to credit coverage based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under paragraph (1). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(3) In the case of an election with respect to a group health plan under paragraph (2) (whether or not health insurance coverage is provided in connection with such plan), the plan shall:

(A) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(B) include in such statements a description of the effect of this election.

(4) Issuer Notice -- In the case of an election under paragraph (2) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:

(A) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(B) shall include in such statements a description of the effect of such election.

(e) Establishment of Period -- Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (g) or in such other manner as may be specified in regulations.

(f) Exceptions:

(1) Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(g) Certifications and Disclosures of Coverage.

(1) A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in paragraph (2):

(A) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(B) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(C) on request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in subparagraphs (A) or (B), whichever is later. The certification under (A) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(2) The certification described in this paragraph is a written certification of:

(A) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(B) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(3) To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this subsection.

(4) Disclosure of Information on Previous Benefits -- In the case of an election described in paragraph (d)(2) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1):

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(5) Regulations -- The commissioner is authorized to establish rules to prevent an entity's failure to provide information with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(h) Special enrollment periods:

(1) For individuals losing other coverage - A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) the employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) the employee's or dependent's coverage described in subparagraph (A):

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after one of the events described in subparagraph (C).

(2) For dependents --

(A) In general, if:

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption, the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period -- A dependent special enrollment period under this paragraph shall be a period of not less than 30 days and shall begin on the later of:

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period -- If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(i) Use of affiliation period by HMOs as an alternative to preexisting condition exclusion-

(1) An HMO which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion

allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) An HMO may use alternative methods from those described in paragraph (1) to address adverse selection as approved by the commissioner.

SECTION 5. (a)(1) Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) To the extent consistent with other sections of this part, paragraph (1) shall not be construed:

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b)(1) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution

for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Nothing in paragraph (1) shall be construed:

(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

SECTION 6. (a) Issuance of Coverage in the Small Group Market.

(1) Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the small group market in Tennessee:

(A) must accept every small employer in Tennessee that applies for such coverage; and

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsistent with Section 5 of this part on an eligible individual being a participant or beneficiary.

(2) Eligible Individual Defined. For purposes of this section, the term "eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined:

(A) in accordance with the terms of such plan,

(B) as provided by the issuer under rules of the issuer which are uniformly applicable in Tennessee to small employers in the small group market, and

(C) in accordance with all applicable State laws governing such issuer and such market.

(b) Special Rules for Network Plans.

(1) In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may:

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated to the commissioner that:

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

(2) An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

(c) Application of Financial Capacity Limits.

(1) A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated to the commissioner that:

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers in the small group market in Tennessee consistent with applicable state law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

(2) A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in Tennessee may not offer coverage in connection with group health plans in the small group market in Tennessee for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. The commissioner may provide for the application of this subsection on a service-area-specific basis.

(d) Exception to Requirement for Failure to Meet Certain Minimum Participation or Contribution Rules.

(1) Subsection (a) shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a health group plan in the small group market, as allowed under applicable State law.

(2) For purposes of paragraph (1):

(A) the term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

(B) the term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(e) Exception for Coverage Offered Only to Bona Fide Association Members. Subsection (a) shall not apply to health insurance coverage offered by a health insurance issuer if such coverage is made available in the small group market only through one or more bona fide associations.

(f) In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer:

(1) shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in subsection (g) and

(2) upon request of such a small employer, provide such information.

(g)(1) Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a small employer, information described in this subsection is information concerning:

(A) the provisions of such coverage concerning issuer's right to change premium rates and the factors that may affect changes in premium rates;

(B) the provisions of such coverage relating to renewability of coverage;

(C) the provisions of such coverage relating to any preexisting condition exclusion; and

(D) the benefits and premiums available under all health insurance coverage for which the employer is qualified.

(2) Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

(3) An issuer is not required to disclose any information under subsection (f) that is proprietary and trade secret information under applicable law.

(h) The requirements of this part addressing the small and large group markets shall not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(i) Rules to be used in the determination of employer size are:

(1) All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(2) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year.

(3) Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

SECTION 7. Guaranteed renewability of coverage for employers in the group market.

(a) If a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan except as provided in this section.

(b) General exceptions -- A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted by this part or other applicable insurance law.

(4) The issuer is ceasing to offer coverage in the market in accordance with subsection (c) and other applicable insurance law.

(5) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and in the case of the small group market, the issuer would deny enrollment with respect to such plan under Section 6(b)(1)(A).

(6) In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

(c) Requirements for uniform termination of coverage.

(1) In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with Tennessee law in the market only if:

(A) the issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(2)(A) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in Tennessee, health insurance coverage may be discontinued by the issuer only in accordance with applicable Tennessee law and if:

(i) the issuer provides notice to the commissioner and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

(ii) all health insurance issued or delivered for issuance in Tennessee in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

(B) In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and Tennessee during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for uniform modification of coverage -- At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan:

(1) in the large group market; or

(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with Tennessee law and effective on a uniform basis among group health plans with that product.

(e) Application to coverage offered only through associations -- In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to `plan sponsor' is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

SECTION 8. Exclusion of certain plans.

(a) Limitation on application of provisions relating to group health plans.

(1) The requirements of this part shall apply with respect to group health plans only:

(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

(2) Treatment of nonfederal governmental plans:

(A) If the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of this part otherwise apply makes an election under this subparagraph pursuant to regulations to be promulgated by the Secretary of HHS, then the requirements of this act insofar as it applies directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

(B) An election under subparagraph (A) shall apply:

(i) for a single specified plan year; or

(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement. An election under subparagraph (i) may be extended through subsequent elections under this paragraph.

(C) Under such an election, the plan shall provide for:

(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees.

(b) Exception for certain benefits. The requirements of this part shall not apply to any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits.

(c) Exception for certain benefits if certain conditions met.

(1) Limited, excepted benefits. The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits, if the benefits:

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits. The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) Supplemental excepted benefits. The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) Treatment of partnerships. For purposes of this part:

(1) Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

(2) In the case of a group health plan, the term ‘employer' also includes the partnership in relation to any partner.

(3) Participants of group health plans. In the case of a group health plan, the term ‘participant’ also includes:

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual, if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

SECTION 9. (a) Except as modified below in this section, this part shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997.

(b) Determination of creditable coverage.

(1) Period of coverage.

(A) Subject to subparagraph (B) no period before July 1, 1996, shall be taken into account in determining creditable coverage.

(B) The commissioner shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for subparagraph (A) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(2) Certifications, etc.

(A) Subject to subparagraphs (B) and (C), the provisions regarding certification shall apply to events occurring after June 30, 1996.

(B) In no case is a certification required to be provided under such subsection before June 1, 1997.

(C) In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(3) Transitional rule. In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996:

(A) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(B) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under this section.

(c)(1) Except as provided in paragraph (b)(2), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this part, this part shall not apply to plan years beginning before the later of the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this part), or July 1, 1997.

(2) Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

SECTION 10. (a) On and after July 1, 1997, each health insurance issuer that offers individual health insurance coverage in Tennessee must offer to and accept for enrollment every eligible individual who applies for coverage without imposing any preexisting condition exclusion with respect to such coverage.

(b) "Eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of periods of creditable coverage is 18 or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

(2) who is not eligible for coverage under a group health plan, Part A or Part B of Title XVII of the Social Security Act, or State coverage pursuant to Title XIX of the Social Security Act (or any successor program), and does not have other health insurance coverage;

(3) whose most recent coverage within the coverage period described in paragraph (1) was not terminated based on nonpayment of premiums or fraud; and

(4) who, if offered the option of continuation coverage, accepted the coverage and exhausted the coverage.

(c) Alternative Coverage Permitted.

(1) In General. The health insurance issuer may elect to limit the coverage offered under subsection (1) so long as it offers at least two different policy forms of health insurance coverage both of which:

(A) are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer; and

(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

For purposes of this subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(2) Choice of Most Popular Policy Forms. The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in Tennessee or applicable marketing or service area (as may be prescribed in regulation) by the issuer in the individual market in the period involved.

(3) Choice of 2 Policy Forms with Representative Coverage.

(A) The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers a lower-level coverage policy form (as defined in subparagraph (B)) and a higher-level coverage policy form (as defined in subparagraph (C)) each of which includes benefits substantially similar to other individual health insurance coverage offered by the issuer in that state and each of which is covered under a mechanism which provides for risk adjustment, risk spreading or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers.

(B) A lower level of coverage policy form provides that the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of a weighted average (described in subparagraph (D)).

(C) A higher level of coverage policy form provides that:

(i) the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the coverage described in subparagraph (B) offered by the issuer in the area involved; and

(ii) the actuarial value of the benefits under the coverage is at least 100 percent but not greater than 120 percent of a weighted average (described in subparagraph (D)).

(D) For purposes of this paragraph, the weighted average is the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the issuer) either by that issuer or by all issuers in Tennessee in the individual market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

(4) The issuer elections under (c)(1) shall apply uniformly to all eligible individuals in this State for that issuer. Such an election shall be made to the commissioner and shall be effective for no less than a 2-year period. An issuer's initial election shall be made by July 1, 1997. All elections shall be in a form and manner as prescribed by the commissioner.

(5) For purposes of paragraph (3), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(d) Special Rules for Network Plans.

(1) In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the issuer may:

(A) limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated to the commissioner that it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees and it is applying this paragraph uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the

individual market within such service area for a period of 180 days after such coverage is denied.

(e) Application of Financial Capacity Limits.

(1) A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer has demonstrated to the commissioner that:

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all individuals in the individual market in the State and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An issuer upon denying individual health insurance coverage in accordance with paragraph (1) may not offer such coverage in the individual market within such service area for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the commissioner that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(3) This subsection may be applied on a service-area specific basis.

(f) The provisions of subsection (a) shall not require a health insurance issuer offering health insurance coverage only in connection with group health plans or through bona fide associations to offer health insurance coverage in the individual market.

SECTION 11. (a) A health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual for all such coverage in effect on or after July 1, 1997, except as provided in this section.

(b) A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) The issuer is ceasing to offer coverage in the individual market in accordance with subsection (c) and other applicable insurance law.

(4) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(5) In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(c) In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if:

(1) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(2) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(3) in exercising the option to discontinue coverage of this type and in offering the option of coverage under paragraph (2), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(d)(1) Subject to paragraph (2), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in Tennessee, health insurance coverage may be discontinued by the issuer only if:

(A) the issuer provides notice to the commissioner and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(B) all health insurance issued or delivered for issuance in Tennessee in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

(2) In the case of a discontinuation under subparagraph (A) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the individual market in Tennessee during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(e) At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with Tennessee law and effective on a uniform basis among all individuals with that policy form.

(f) In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association (of which the individual is a member).

SECTION 12. The provisions for certification and disclosure of coverage shall apply to health insurance coverage offered by a health insurance issuer in the individual

market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

SECTION 13. The individual market requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in Section 3(10)(A) or to those described in Section 3(10)(B), (C), or (D) if the benefits are provided under a separate policy, certificate or contract of insurance. A health insurance issuer offering health insurance coverage in connection with group health plans shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

SECTION 14. (a) The provisions of this part are supplemental to any other provisions of the laws of this state. However, to the extent that these provisions are in conflict with other provisions of insurance law, the provisions of this part shall control.

(b) No enforcement action shall be taken, pursuant to this part, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by this part before January 1, 1998, or, if later, the date of issuance of the federal regulations to be issued pursuant to the federal act if the plan or issuer has sought to comply in good faith with such requirements.

SECTION 15. It is the intent of this part to meet the minimum standards established by the federal Health Insurance Portability and Accountability Act of 1996 and the rules and regulations to be promulgated by federal authorities in connection with that act. The commissioner is, therefore, authorized to promulgate rules and regulations, pursuant to the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5, as may be necessary to ensure compliance with the federal law as well as those rules necessary to carry out the proper administration of this part.

SECTION 16. If any provision of this part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the part which can be given effect without the invalid provision or application, and to that end the provisions of this part are declared to be severable.

SECTION 17. Tennessee Code Annotated, Section 56-7-2601, is amended by adding the following language as a new subsection:

(g) In general, with respect to group health plans issued by entities regulated pursuant to insurance law, for plan years beginning on or after January 1, 1998, certain mental health benefits are required as follows:

(1) As to either aggregate lifetime limits or annual limits or both, for a group health plan providing both medical and surgical benefits and mental health benefits-

(A) If the plan does not have a limit on substantially all medical and surgical benefits, the plan may not impose any such limit on mental health benefits.

(B) If the plan has a limit on substantially all medical and surgical benefits, the plan shall either include mental health benefits under the limit applied to medical and surgical benefits or apply a separate limit to mental health benefits that is no less than the one applied to medical and surgical benefits.

(C) If the plan has varying limits on different medical or surgical benefits, the plan shall apply an average limit to mental health benefits with the average to be computed based on the weighted average of the varying limits.

(D) "Aggregate lifetime limit" means a dollar limitation on the total amount that may be paid for benefits under a health plan with respect to an individual or other coverage unit.

(E) "Annual limit" means a dollar limitation on the total amount that may be paid for benefits in a 12-month period under a health plan with respect to an individual or other coverage unit.

(2) No group health plan is required under this subsection to provide mental health benefits.

(3) This subsection shall not affect the terms and conditions related to the amount, duration or scope of mental health benefits except for aggregate lifetime limits and annual limits.

(4) This subsection shall not apply to group health plans issued to small employers, defined as those with from 2-50 employees.

(5) This subsection shall not apply if its application results in an increase in the cost of the coverage of at least 1 percent.

(6) If the group health plan offers a participant 2 or more benefit package options, the provisions of this subsection shall be applied separately to each option.

(7) For purposes of this subsection, the term mental health benefits does not include benefits for the treatment of substance abuse or chemical dependency.

(8) This subsection shall not apply to benefits for services furnished on or after September 30, 2001.

(9) The commissioner may promulgate such reasonable rules and regulations as may be necessary for the proper administration of this subsection.

SECTION 18. This act shall take effect upon becoming law, the public welfare requiring it.